April 24, 2025 Audit & Compliance Committee

4/24/2025 12:00:00 AM 02:30 PM

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VIRGINIA STATE UNIVERSITY BOARD OF VISITORS
COMMITTEE ON AUDIT AND COMPLIANCE
2:30 P.M.; THURSDAY, APRIL 24, 2025
Gateway Dining & Events Center
(on the campus of Virginia State University)
(No Public Comment Period Scheduled)

DRAFT AGENDA

CALL TO ORDER ..... Mr. Jon Moore, Chair

ROLL CALL

INVOCATION

APPROVAL OF AGENDA

APPROVAL OF PREVIOUS MEETING MINUTES (if any)

- February 6, 2025 Meeting Minutes

PRESIDENT'S REMARKS…….…...….. Dr. Makola M. Abdullah

REPORTS AND RECOMMENDATIONS

Introduction- "Guidance and Growth to Greater: VSU's Continuous Improvement Journey"

Information Items:

Presenters: Ms. Shawri King-Casey, Vice President, Institutional Integrity & Compliance
Ms. Nannette Williams, Chief Audit Executive

- FY24 APA Audit Update.....Ms. Shawri King-Casey, Vice President of Institutional Integrity & Compliance

- Internal Audit Update…….Ms. Nannette Williams, Chief Audit Executive
  a. Current Audit Plan Progress Update
  b. 2025-2026 Audit Plan and Risk Assessment – progress to date on new plan
  c. External QAR Results

CONCLUSION

OTHER BUSINESS

ADJOURNMENT

4.16.25

VIRGINIA STATE UNIVERSITY BOARD OF VISITORS
COMMITTEE ON AUDIT AND COMPLIANCE
3:30 P.M., THURSDAY, FEBRUARY 6, 2025
Gateway Dining & Event Center, 2nd Floor
(No Public Comment Period Scheduled)

DRAFT AGENDA

CALL TO ORDER ..... Ms. Daphne Meeks, Vice Chair

ROLL CALL

INVOCATION (*(Pastor Seth Gooden, Director of Campus Ministries)*

APPROVAL Of AGENDA

APPROVAL OF PREVIOUS MEETING MINUTES (if any)
- ∑ November 14, 2024 Meeting Minutes

PRESIDENT'S REMARKS..... Dr. Makola M. Abdullah

CLOSED SESSION (if any)

REPORTS AND RECOMMENDATIONS

A. Infrastructure Update
   a. FY 23 APA Audit Recap and FY24 Audit in Progress – Latoya Jordan and Staci Henshaw, Auditor of Public Accounts Presentation
   b. Brief Management Response - Shawri King-Casey, VP of Institutional Integrity and Compliance

B. Internal Audit Report – Nannette Williams, Chief Audit Executive
   1. Audit Plan Progress Update
   2. Internal Quality Assurance Review Report
   3. External Quality Assurance Review Update

CONCLUSION

ADJOURNMENT

1.28.25

VIRGINIA STATE UNIVERSITY BOARD OF VISITORS
COMMITTEE ON AUDIT AND COMPLIANCE
DRAFT MEETING MINUTES
THURSDAY, FEBRUARY 6, 2025

CALL TO ORDER
Visitor Meeks called the Audit and Compliance Committee meeting to order at 3:00 PM at The Gateway Dining & Event Center, 2nd Floor 2804 Martin Luther King Drive, located on the Campus of VSU.

ROLL CALL
A quorum was present.

COMMITTEE MEMBERS PRESENT:
Dr. Valerie K. Brown
Dr. Joseph A. F. Chase, Jr.
Dr. Harold Green, Jr.
Dr. Leonard Haynes, III
Ms. Daphne Meeks
Mr. Jon Moore (Chair) *absent*
Mr. Robert Thompson

BOARD APPOINTEES:
Dr. Tracy Jackson, Faculty Representative
Mr. Yousif Omer, Student Representative (Absent)

OTHER MEMBERS PRESENT:
Dr. Robert Denton, Jr.
Mr. Peter McPherson
Ms. Verndell Robinson
Mr. Victor Branch
Mr. Robert Thompson

ADMINISTRATION PRESENT:
Dr. Makola M. Abdullah, President
Dr. Tia Minnis, Provost/Vice President for Academic and Student Affairs
Ms. Tonya S. Hal, Vice President for Advancement and External Engagement
Mr. Kevin Davenport, Senior Vice President for Finance & Administration/CFO
Ms. Shawri King-Casey, Vice President for Institutional Integrity & Compliance
Dr. Alexis Brooks-Walter, Vice President for Student Affairs/Enrollment Management
Dr. Annie C. Redd, Chief of Staff/Director, Board Operations & Relations

AUDIT AND COMPLIANCE
COMMITTEE MEETING MINUTES
THURSDAY, FEBRUARY 6, 2025
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LEGAL COUNSEL
Mr. Nathan Moberly

INVOCATION
The Chair called Pastor Seth Ahmad-McQueen, to deliver the invocation.

APPROVAL OF AGENDA
The Committee approved the agenda by voice vote.

APPROVAL OF PREVIOUS MEETING MINUTES
The Committee approved the minutes from the meeting on November 15, 2024, by voice vote.

PRESIDENT'S REMARKS
President Abdullah gave his time to the presenters.

CLOSED SESSION
Chair Moore asked for a motion to enter a closed session for the discussion or consideration of personnel matters pursuant to 2.2-3711(19), Discussion of plans to protect public safety as it relates to terrorist activity or specific cybersecurity threats or vulnerabilities and briefings by staff members, legal counsel, or law-enforcement or emergency service officials concerning actions taken to respond to such matters or a related threat to public safety; discussion of information subject to the exclusion in subdivision 2 or 14 of § 2.2-3705.2, where discussion in an open meeting would jeopardize the safety of any person or the security of any facility, building, structure, information technology system, or software program; or discussion of reports or plans related to the security of any governmental facility, building or structure, or the safety of persons using such facility, building or structure; namely, the findings of the cybersecurity investigation performed by the Office of the State Inspector General (OSIG) and the findings of the Medicat audit performed by the Virginia State University Internal Audit Office.

Upon returning to open session, the Committee certified that during its closed meeting, the committee discussed only public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of Information Act, and only those public business matters identified in the motion convening the board in closed session. The motion was made, properly seconded, and approved by roll call vote.

REPORTS & RECOMMENDATIONS
AUDIT AND COMPLIANCE COMMITTEE
MEETING MINUTES THURSDAY, FEBRUARY 6, 2025
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REPORTS & RECOMMENDATIONS
Vice President of Institutional Integrity & Compliance Shawri King-Casey welcomed everyone and presented Auditor of Public Accounts (APA) Staci Henshaw, who will address the fiscal year 2023 (FY23) and fiscal year 2024 (FY24) audits.
Ms. Henshaw gave a summary of her position and the APA Office. Due to her impending transfer to another Commonwealth department, she announced a modification to the FY24 audit that includes replacing the incumbent audit-in-charge, Ms. LaToya Jordan. According to Ms. Henshaw, the APA Office will be the source of the new project manager, and the choice will be made in a way that guarantees a seamless transfer without affecting the audit's timeline.

Ms. Henshaw then gave some more opening remarks about her wish to make sure that the future of VSU's audits in FY24 and beyond represented a seamless procedure. In keeping to work together to achieve ongoing improvement, Ms. Henshaw asked the Committee members to get in touch with her directly if they had any questions.

Following her opening remarks, Ms. Crenshaw focused her presentation on the audit results for FY23. According to Ms. Henshaw, the audit took place between July 2022 and June 2023. Ms. Henshaw stated that the audit was conducted between February and August of 2024, with a majority of the fieldwork completed in February. The audit's goals, which included a review of financial statements, internal controls, compliance, and deficiencies, were then explained by Ms. Crenshaw.

As for the more specific details about the audit results, according to Ms. Henshaw, VSU received an unmodified opinion on its financial statements and the University’s Foundation statements. The internal control report was issued in November 2024, although September 2024 was the date the APA had all of the necessary information to draft its opinion. Ms. Henshaw acknowledged that the University is making good progress as it has reduced its findings from 18 to 5 in a matter of 3 audit cycles.

Regarding the statewide single audits, Ms. Henshaw discussed VSU’s outstanding findings and the current status. Under the compliance objective, there were three (3) instances of non-compliance in IT. No fraud or illegal acts were found. There were no material changes to significant accounting policies. The Significant Accounting Estimates were reasonable and fairly stated. There was proper treatment of accounting principles with no material alternative principles and no disagreement with management regarding this issue. Significant audit adjustments were listed in the financial report findings. Finally, VSU had one uncorrected misstatement in its financials that was inconsequential.

Upon the conclusion of Ms. Crenshaw’s presentation and a brief question-answer period, the Committee moved to a closed session. The Committee re-entered the open session at 3:57 PM and continued with questions.

AUDIT AND COMPLIANCE COMMITTEE
MEETING MINUTES
THURSDAY, FEBRUARY 6, 2025
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Visitor Haynes inquired about whether the APA audit teams compare and contrast information or share processes as they all conduct audits for other institutions.

Ms. Henshaw explained that there are some things done across the board. Internal work papers are open to review by audit teams but typically not to the public to exemptions under Virginia's Freedom of Information Act. Higher education audit teams do come together to share advice and efficiencies.
Visitor Haynes asked a follow-up question regarding whether informal opinions are offered. Ms. Henshaw responded that sometimes there is sharing of information which can include recommendations. Ultimately, per Ms. Henshaw, decisions about the audit rest with the audit's project manager and Ms. Henshaw. There being no further questions, Ms. Henshaw yielded the podium to VP King-Casey and Ms. Williams.
VP King-Casey thanked the APA for collaboration noting that the FY24 entrance conference occurred before the University's winter break. Internally, the University's staff has held an audit intake meeting to proactively prepare for the FY24 audit. VP King-Casey gave kudos to the University's Financial Aid Department, complimenting the unit's success in the state single-wide audit and highlighting the positive remarks from the auditor regarding the working relationship. After a recap of the FY23 report and an update on the status of corrective actions, VP King-Casey yielded the floor to Ms. Williams for the Internal Audit team updates.
Ms. Williams provided an overview of Internal Audit's audit activity noting the conclusion of some audits with target dates for reports and the initiation of other audits. Ms. Williams also provided a status update on the Quality Assurance Review (QAR) audit informing that she anticipated the external QAR audit to be concluded by the end of February. As for the internal QAR, Ms. Williams shared that her office is mostly compliant with standards. She explained that the issues identified primarily centered around working out kinks associated with the use of the automated audit management system.
There being no follow-up questions, Ms. Williams concluded her report.

ADJOURNED
Visitor Meeks called for a motion to adjourn it was moved, properly seconded, and voted on to adjourn. The meeting was adjourned at 4:12 PM.

APPROVED:

_____ _____
Chair Date

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Virginia State University
Board of Visitors
Audit & Compliance Committee

Shawri King-Casey VP, Institutional Integrity & Compliance
Nannette Williams, Chief Audit Executive

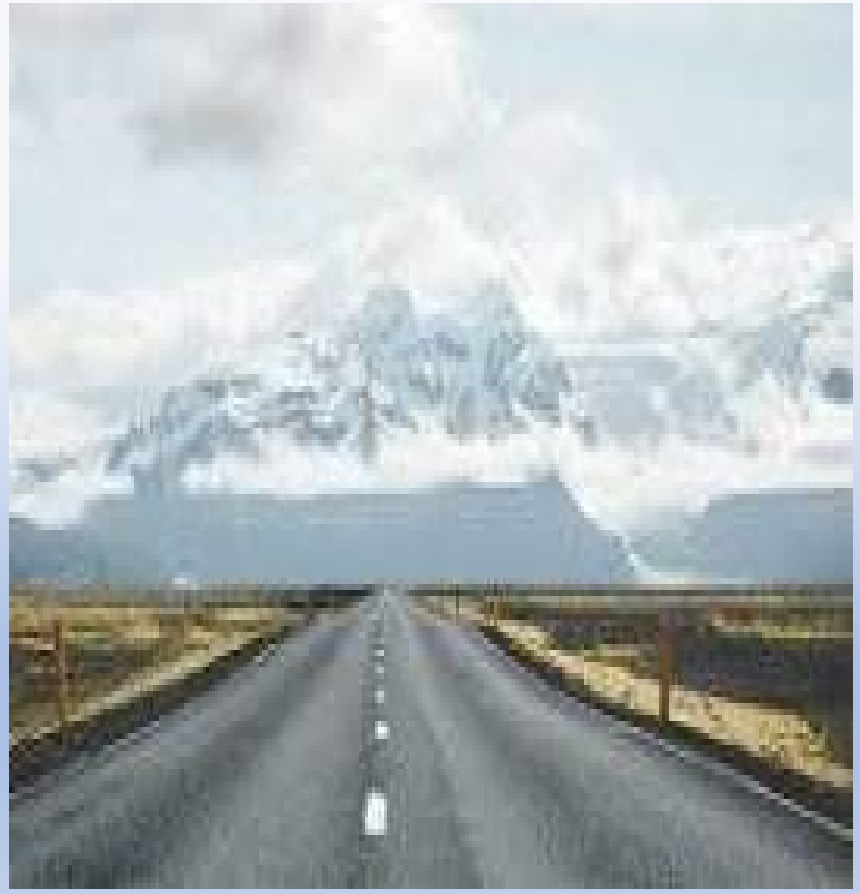
November 14, 2024

Greater Insights, *Greater* Improvements – *Gathering Actionable Intelligence and Gaining Ground*: A Snapshot of VSU's Audit & Compliance Efforts

VSU Priority 5:
Diversify Financial Resources and Enhance Operational Effectiveness

FY24 Audit Update

- April Cassada, New Project Manager
- Shahbaz Aftab, Audit-in-Charge
- Bi-weekly Meetings
- Fieldwork in Progress
- Draft Report Soft Deadline



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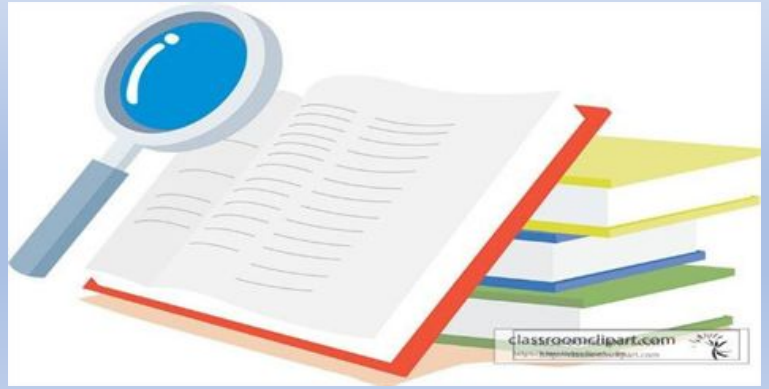
Internal Audit Update



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Internal Audit Update Agenda

I. Audit Status/Progress since last meeting

II. IT Security Audit Reports

III. FY 2026 Risk Assessment and Audit Plan Creation Progress

IV. External Quality Assessment Review Results

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Where are we now?

- Travel Charge Card Program audit is complete, we have issued a draft report, and anticipate issuing a final report this month
- The Capital Outlay audit is resuming
- The Cashier Operations Audit is underway
- The Travel Reimbursement Audit is starting
- There are 2 completed IT Security Audits included in your packets

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IT Security Audit Reports

- You have 2 reports included in your packets:

1. Configuration Management
   - There were no findings

2. Banner IT Security Report
   - There was one finding

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Where are we Going?

- **We have just finished updating a new University-Wide Risk Assessment Questionnaire that we anticipate sending out this week.**
- **We will use the results, along with Internal Audit brainstorming sessions, to inform the basis of our FY26 Workplan**
- **This year, to conform with the new Institute of Internal Audit (IIA) standards, we will also complete an Internal Audit strategic plan that aligns with the University's Strategic Plan.**

EXTERNAL QUALITY ASSURANCE REVIEW RESULTS

VIRGINIA STATE UNIVERSITY

March 14, 2025

Third Line Consulting LLC

Report Contents

03 **Background**
Overview of Engagement & Results

04 **EQAR Rating Categories**
IIA Standard Ratings Described

05 **EQAR Procedures**
Highlights observed

06 **Observed Qualities of Strength**
Improvements identified

07 **EQAR Summary & Detailed Observations**
Improvements identified and ratings assessed by standard

EQAR Background

- VSU's Internal Audit Department (IA) follows the Institute of Internal Auditors International Professional Practices Framework (IPPF) as required by the Office of the State Inspector General (OSIG).
- The IPPF requires an external quality assessment review (EQAR) be conducted at least once every five years by a qualified, independent assessor or assessment team from outside the organization.
- Third Line Consulting, LLC (TLC) was engaged to perform a full assessment of the IA function and audit work plan.
- Fieldwork conducted October 2023 through February 2025. Review period primarily focused on calendar year 2022-2024 activities.
- Assessment performed utilizing the IIA's Quality Assurance Manual (QAM), which provides a standard approach to performing, assessing, and reporting on the Internal Audit function for this external quality assessment, in accordance with the IIA's quality standards, specifically section 1300 standards that outline the Quality Assessment and Improvement Program.

Overall Rating Categories

Generally Conforms

Internal audit activity has a charter, policies, and processes that are judged to generally be in conformance with the Standards and the Code of Ethics.

Partially Conforms

Deficiencies were found in practice that deviate from the Standards and the Code of Ethics; however, it did not preclude the internal audit activity from performing in an acceptable manner.

Does not Conform

Significant deficiencies found in practice that deviate from the Standards and the Code of Ethics, that seriously impair or preclude adequate performance in all or in significant responsibilities.

The IIA QAM provides three categories for rating the quality of an IA department

EQAR Procedures Performed

- **Surveyed Stakeholders**
- Obtained completed questionnaires and Interviewed a sample of Stakeholders including: Internal
- Audit, AC & Board members, Executive management, auditees.

- **Reviewed Documentation**
- Evaluated IA Charter, IA Manual, AC Presentations, Audit Reports and a sample of Workpaper over the review period, as well as monitoring documentation, and evidence of required continuing education.

- **Assessed Compliance with IA Standards**
- Using the IA QAM, completed an objective and independent assessment, maintaining integrity and a commitment to provide quality insights.

Third Line Consulting LLC

VSU IA Areas of Strength

Proper Reporting Structure

IA reporting structure both functionally and adminstratively conducive to independence performance & reporting

Strong Policies & Procedures

IA Charter and IA Manual include required elements and are reviewed and approved periodically

Improving Risk Culture

IA and Risk personnel have helped develop a more risk aware and focused culture and are building trusted advisor relationships

Accurate Self Assessment

IA's recently completed thorough self-assessment was performed with objectivity and integrity, aligning with our conclusions.

SUMMARY OF OBSERVATIONS

It is our overall opinion that IA **GENERALLY CONFORMS** with the Standards and the Code of Ethics. We did identify areas of non-compliance with the standards where improvements are recommended. Outlined below are the main improvements identified, which are further detailed in the remainder of the report, along with specific rating conclusions for each standard reviewed.

- **No formalized periodic presentation of the review of IA Independence with the Audit Committee**
- **Workpapers were missing sufficient documentation to support findings detailed in the report**
- **Supervisory review of engagement workpapers was not consistently documented**
- **There was limited evidence to support additional ongoing monitoring efforts**
- **No clear alignment of Internal Audit Plan to VSU Strategic Objectives**
- **Missing evidence of completion of required continuing education requirements**

MISSING ANNUAL IA INDEPENDENCE CERTIFICATION TO BOARD

Observation: While the audit team members individually documented their attestation of independence in 2023 and 2024, the Internal Audit team's independence was not formally presented to the Audit Committee annually. Based on interviews with IA management, it was clear that any independence concerns would be raised to the Audit Committee, however there was no process in place to formally evaluate and communicate the consideration of independence throughout the year as non-audit duties or projects arise.

CRITERIA

1110 Independence & Objectivity: The chief audit executive must confirm to the board, at least annually, the organizational independence of the internal audit activity. 2060 – Reporting to Senior Management and the Board: The chief audit executive must report periodically... Interpretation: The chief audit executive's reporting and communication to senior management and the board must include information about:...- Independence of the internal audit activity.

CAUSE

An annual attestation is completed by the staff in both 2023 and 2024. Requirements were misunderstood to be required on an exception bases, where reporting to the Board was required only when any independence concerns were identified.

EFFECT

The Audit Committee may not have the information necessary to fulfill its obligations for reviewing IA independence and objectivity. Independence considerations may not be evaluated thoroughly when performing non-audit services or projects.

RECOMMENDATION

We recommend a formal discussion be included on the Audit Committee Agenda, at least annually, regarding IA Indepedence. As also recommended in the recent internal assessment, it is also recommended to implement a policy requiring auditors to evaluate and report any potential independence or objectivity impairments as they arise throughout the year both internally and with the Audit Committee.

Management Response: Internal Audit will formally document and present an annual independence confirmation to the Audit Committee. A policy will be implemented requiring auditors to evaluate and report potential independence impairments as they arise throughout the year.

INSUFFICIENT EVIDENCE TO SUPPORT CONCLUSIONS

Observation: In one of the 3 sampled engagement's workpapers reviewed, the workpapers did not include sufficient documentation to support audit procedures performed and fully developed conclusions reached to enable an independent reviewer to easily tie conclusions reached in the report. There was limited explanation regarding testing performed and while high level issues were noted, these issues were not fully developed within in the workpapers to support the findings as outlined in the report.

CRITERIA

2320 Analysis and Evaluation: Internal auditors must base conclusions and engagement results on appropriate analysis and evaluations. 2330 Documenting Information: Internal auditors must document sufficient, reliable, relevant, and useful information to support the engagement results and conclusions.

CAUSE

Workpaper documentation methodology is not consistent across engagement types, making it difficult to ensure appropriate levels of documented are created and retained to support the testing performed and results. For this specific engagement, the summary of findings that provided a clear outline of the findings to be tied to the report was not retained in the workpaper folder.

EFFECT

Without clear documentation to support testing performed and mapping of findings to the report, there is risk that findings and observations are not accurately reported to management and the Board. With the limited documentation available to support testing efforts, adequate supervisory review requires duplicating efforts to reperform testing, which is inefficient.

RECOMMENDATION

More consistent and complete documentation should be created and retained, including standardizing and fully utilizing the automated workpaper system across engagements. There should be clear traceable support for specific testing performed, issues identified, with required finding details in the workpapers to allow for the clear mapping to the report issued. Workpapers should include criteria, materiality, risk tolerance, and cost-benefit analysis performed.

Management Response: Internal Audit will ensure all conclusions are supported by sufficient evidence and traceable documentation to meet Standard 2330. While the use of Pentana is encouraged, audit teams may use alternative documentation methods as long as they maintain sufficient and reliable evidence to support audit conclusions. Workpaper templates will be reviewed to ensure they adequately support purpose, scope, source, and conclusion.

INCONSISTENT EVIDENCE OF SUPERVISION ACTIVITIES

Observation: Workpaper files did not consistently show evidence of adequate supervisory review and approval. In 2 of the 3 audit workpapers selected for review, numerous work papers did not have evidence, either in the automated system or on supporting testing workpapers, that supervisory review and approval occurred. On workpapers where review evidence was apparent, there were open comments and unimplemented recommendations, and were missing final supervisor approval. Inconsistent evidence of supervisory review was also noted in the internal assessment. No additional documentation such as status meeting agendas, minutes, or emails were available to support supervision an ongoing monitoring efforts.

CRITERIA

2340 Engagement Supervision: Engagements must be properly supervised to ensure objectives are achieved, quality is assured, and staff is developed. Appropriate evidence of supervision is documented and retained.

CAUSE

Automated workpaper system issues occurred that are still in the process of being addressed by the vendor. Additionally, depending on the type of engagement and auditor, the workpaper methodology is not consistent making it difficult to ensure consistent evidence of review and approval. Due to the department having a small staff, status meetings were more informal.

EFFECT

Without consistent documented supervision and evidence of independent review of audit work, there is limited support of ongoing quality control efforts, and audit results communicated to management may not be accurate.

RECOMMENDATION

Independent review should be performed and documented consistently for all engagements. This includes documenting supervisory review, identifying and addressing comments, and conducting a final review, in a timely and efficient manner. Evidence to support other ongoing monitoring efforts should be maintained, in an efficient manner to not add undue burden.

Management Response:
Supervisory review documentation will be strengthened to ensure compliance with engagement supervision requirements.

LIMITED EVIDENCE OF ONGOING MONITORING

Observation: There is limited documentation to support the ongoing monitoring portion of the quality assurance and improvement efforts throughout the period. While there is evidence of a thorough internal assessment performed in FY2025 and a previous External Assessment in 2019, documentation of ongoing monitoring efforts was limited to inconsistent evidence of supervisory review of workpapers. Performance metrics have not been established, monitored, and evaluated to provide accountability. This was also identified in the internal assessment. External surveys have not been instituted, which was also noted in the previous external quality assessment and the recent internal assessment.

CRITERIA

1300 – Quality Assurance and Improvement Program; The chief audit executive must develop and maintain a quality assurance and improvement program that covers all aspects of the internal audit activity. 1311-Internal Assessments: Internal Assessments must include: Ongoing monitoring of the performance of the internal audit activity...Interpretation- Ongoing monitoring is an integral part of the day-to-day supervision, review, and measurement of the internal audit activity.

CAUSE

There were multiple CAEs during the period and the department was operating with limited staff during the period. The IA team was working to become a trusted advisor. While additional monitoring efforts, such as team status calls were held routinely, they were more informal and not documened.

EFFECT

Without more formal tracking of audit progresss, performance metrics and survey results, Internal Audit staff may not being measured formally on quality, efficiency, and effectiveness of services provided and may not be using resources as efficiently or effectively as possible. Without survey results, feedback on the success of the Departments initiatives towards becoming a trusted advisor and further recommendations were not formally obtained.

RECOMMENDATION

Ongoing monitoring efforts should include formally tracking audit progress, establishing and measuring against performance metrics, as well as implementing an auditee survey process. IA should consider how to most efficiently capture information needed to measure and evaluate against strategically important metrics. These should include departmental and auditor specific performance goals. Surveys can be sent using automated technology. Communication should occur periodically with the Audit Committee related to the established performance metrics.

Management Response: Internal Audit will enhance the QAIP section of the Audit Manual, detailing the scope, objectives, and processes for internal and external assessments. A self-assessment schedule will be established as part of QAIP, ensuring consistent evaluations of conformance. Performance metrics will be developed and monitored, focusing on efficiency, cost-effectiveness, and advisory impact. As part of this effort IA will utilize the survey function in Pentana and send out surveys at the conclusion of each engagement.

NO CLEAR ALIGNMENT OF INTERNAL AUDIT PLAN TO VSU STRATEGIC OBJECTIVES

Observation: There was not clear documentation available to support the correlation between the IA plan and the organization's strategic objectives. There are numerous University initiatives that Internal Audit is involved in that focuses on addressing risks related to organizational objectives and IA considers strategic risks during the risk assessment process, however, there is not documentation available to support the specific correlation from risk assessment to the internal audit plan. This was also identified in the internal assessment. Additionally, there is no defined risk appetite statement available for Internal Audit to assess whether appropriate risk responses are selected that align with the organization's risk appetite.

CRITERIA

2120 – Risk Management
internal auditor's assessment that:
-Organizational objectives support and align with the organization's mission... Appropriate risk responses are selected that align risks with the organization's risk appetite. 2120.A1 – The internal audit activity must evaluate risk exposures relating to the organization's governance, operations, and information systems regarding the: Achievement of the organization's strategic objectives.

CAUSE

While VSU has a number of individuals focused on Risk Management activities, and developing a risk focused culture, the typical enterprise risk management program is still developing. Internal audit created its audit plan through an internal risk assessment process with management interviews for FY 2024 and a benchmarking analysis to develop the FY 2025 audit plan.

EFFECT

Without such alignment, Internal Audit resources may not be focused on areas that provide the most risk to meeting VSU strategic objectives. Without a clear risk appetite statement, the various risk management personnel may not be focused on key risks that fall outside VSUs risk appetite.

RECOMMENDATION

VSU should create a risk appetite statement and conduct a full enterprise risk assessment. Now that VSU is more focused on risk identification and mitigation, a full assessment will identify high risk areas and evaluate where further mitigation plans are needed and identify owners. IA should piggyback its internal audit plan risk assessment with the enterprise risk assessment and document its correlation to the internal audit plan.

Management Response: Internal Audit will integrate strategic alignment into the risk assessment process. Risk assessment templates will be updated to explicitly link risks to VSU's strategic objectives. Internal Audit will also develop a strategic plan aligned with the VSU Strategic Plan.

MISSING EVIDENCE OF COMPLETION OF REQUIRED CONTINUING EDUCATION

Observation: Documentation was not available to support that required continuing education requirements were met to fulfill active CPA and CFE license requirements for the CAE. This included missing support for some of the total required hours required during 2022-2025 as well as required ethics training for 2022. The internal assessment also identified the need for better tracking of continuing education requirements and completions.

CRITERIA

1230 Contiuing Professional Development: nternal auditors must enhance their knowledge, skills, and other competencies through continuing professional development. VA Board Accountancy 18VAC5-22-90 and 18VAC5-22-140 requires active CPAs must complete the required 120 CPE hours over a rolling three-year period, with a minimum of 20 hours annually. The CPE requirement also includes completing a two-hour VBOA-approved ethics course annually. The Association of Certified Fraud Examiners requires CFEs to obtain a minimum of 20 CPE credits each year; at least 10 of these must relate directly to the detection and deterrence of fraud and 2 must relate directly to ethics.

CAUSE

While there was a centralized repository and a tracking system has been created for auditors to populate, it was complex and not used consistently among the team. Some missing records were due to not retaining completed course certificates properly during job transitions.

EFFECT

Without documentation maintained to support continuing education requirements, the auditor is at risk of being disciplined by licensing boards. By not taking required continuing education, the auditor is at risk of losing proficiency and credibility.

RECOMMENDATION

IA should establish a simple tracking system to be used consistently for the audit team, which includes both planned and completed courses, allowing for the budgeting and allocation of resources to enable meeting all ongoing education requirements. CPE certificates should be maintained centrally as well as individually, as it is the responsibility of each auditor to maintain this evidence in the event of an audit. IA should consider online CPE sites which provide inexpensive opportunities for the staff to work towards and earn certifications to enhance team knowledge and creditability.

Management Response: Internal Audit has subscribed to My-CPE, an online continuing professional education platform, to facilitate tracking and compliance with professional development requirements.The audit team’s CPE records will now be maintained centrally using My-CPE's built-in compliance tracking tools. A quarterly review process will be implemented to ensure timely completion of required CPE hours.

Third Line Consulting LLC

EQAR Conducted by

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Thank you for the opportunity to be of service!

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QUESTIONS?

Office of Internal Audit

Virginia State University

Banner IT Security Audit Report

Internal Audit Report

November 18, 2024

This report is Freedom of Information Act Exempt (FOIAE) under § 2.2-3705.2 of the Code of Virginia due to it containing descriptions of security mechanisms

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EXECUTIVE SUMMARY

BACKGROUND

Banner is Virginia State University's cloud-based enterprise resource planning system that integrates the student and faculty finance and administrative services. Banner interfaces with 13 systems which are Encompass, Slate, Medicat, Adirondak, Canvas, Nelnet, TK20, Cardinal Finance, Ticketrak, ChromeRiver, Collegiate Link, ID Network and Courseleaf. Banner currently has approximately 638 users, each of whose permissions within the system are based on their roles and responsibilities. Virginia State University has classified Banner as a sensitive system with respect to confidentiality, availability and integrity as it contains records with personal identifiable information. Banner is a hosted, or Software as a Service (SaaS) system, that currently uses AWS as its data center hosting service.

Our audit of Virginia State University's enterprise resource planning system, Banner, focused on three control families from the Commonwealth of Virginia Information Security Standard (SEC 530) and Virginia State University Information Technology policies. These three control families provide a framework of minimal requirements that commonwealth agencies use to develop their information security programs, with a goal of allowing agencies to accomplish their missions in a safe and secure environment. These three control families were selected because of the sensitivity of the Banner system. These control families represent three pillars to successfully adhere to the "CIA triad", which are confidentiality, integrity, and availability.

The Control Families selected are:

Access Control - (AC)**:**
The Access control family is a fundamental component for data security that dictates who can access and use company information and resources. Through authentication and authorization, access controls ensure users are who they say they are and that they have appropriate access to company data.

System and Communication Protection - (SC):
The System and Communication Protection control family is responsible for systems and communication protection procedures. This includes boundary protection, protection of information at rest, collaborative computing devices, cryptographic protection, denial of service protection, and many others.

Configuration Management**:**
The System and Information Integrity control family provides assurance that only approved changes to information system are done. And ensures that there is an automation change control system in place. Change request are retained. Impact analyses are completed to identify risk and that is a role back procedure in place.

EXECUTIVE SUMMARY

SCOPE AND OBJECTIVES

The Office of Internal Audit has completed its Banner Information Technology (IT) Security Audit, which was included in the fiscal year 2024 Audit Plan. This report provides an analysis of the current IT controls surrounding Banner and their effectiveness, and offers recommendations for improving security measures to mitigate potential vulnerabilities and threats. The audit scope included an evaluation of the University's security infrastructure, policies, and procedures as they relate to Banner. The objectives were to test the adequacy and effectiveness of the University's security controls and configurations protecting the Banner system, and to ensure the controls in place are compliant with applicable state and federal laws, regulations, standards, and industry best practices. The steps performed were intended to provide reasonable assurance that the controls are working to protect the confidentiality, integrity, and availability of data within the Banner system.

We reviewed for compliance with the University information technology (IT) security policies and procedures, and three of the 20 SEC 530 IT security control families: Access, System and Communication Protection and System, and Information Integrity.

CONCLUSION

Overall, the University's IT security for Banner is adequate, however, opportunities exist to strengthen and enhance the IT security for Banner. This report outlines one recommendation. Included in the table below is a summary of the observations ranked by internal audit's risk definition and classification. See Appendix A for risk rating classifications and definitions.

Priority (0)	High (1)	Medium (0)	Low (0)	Total (0)

The findings below have been presented to management. Management has plans to address the issues identified in the report. These responses, along with the findings and recommendations, are in the Findings, Recommendations, and Responses section of this report. They are listed in order of priority.

In conclusion, we have identified areas for improvement within Virginia State University's Banner system. By implementing the recommendations outlined in this report, the University can enhance its overall security resilience and reduce the risk of Banner system threats.

FINDINGS, RECOMMENDATIONS, AND RESPONSES

Observation	Recommendation	Management Response
Risk Rating: High *Requirement – Access permissions are managed incorporating the principles of least privilege and separation of duties. Control- Access Control.* **1. AC -2 COV (A. 2.) Disable unneeded accounts in a timely manner.** The University does not disable unneeded accounts in a timely manner of its Banner system compliant with the Commonwealth's Security Standard section AC-2 Account Management and the University's Logical Access Control and Account Management Policy. These require that the system administrator/owner will disable unneeded accounts in a timely manner. The review of the user list and the separation list showed that there were users no longer employed with VSU that still had access to Banner. Failure to not disable unneeded accounts in a timely manner can lead to unauthorized access and the risk of a data breach.	We recommend that the Virginia State University ensure it has a tested, proven process to disable accounts in a timely manner from all University systems. By disabling unneeded accounts, the University can ensure that all granted user access rights giving access to Banner are appropriate and legitimate. In so doing, the University will decrease risk and lessen the potential for data breaches or unauthorized access to Banner System.	Concur – The IT Account Management Team are working with HR to get weekly reports of departed/departing employees. The University has procured Okta to assist with disabling access in a timely fashion. We have also moved from disabling accounts after a "no log in" for 90-day period, to a 30 day no login to reduce the potential threat vector. The issue revolves around our PO based consultants and adjunct contractors.

APPENDIX A - RISK DEFINITION AND CLASSIFICATIONS

As you review each finding within the Findings, Recommendations and Management Responses section of this report, please note that we have included a color-coded depiction as to the perceived degree of risk represented by each of the observations identified during our audit. The following chart provides information with respect to the applicable definitions and terms utilized as part of our risk ranking process:

	Degree of Risk and Priority of Action	
Risk Definition: the possibility of an event occurring that will have an impact on the achievement of objectives. Risk is measured in terms of impact and likelihood.	**Priority**	An issue identified by Internal Audit that, if not addressed immediately, has a high probability to directly impact achievement of a strategic or important operational objective of a VSU business unit or the University as a whole.
	High	A finding identified by Internal Audit that is considered to have a high probability of adverse effects to the University either or to a significant college/school/business unit. As such, management should act to address the noted concern and reduce risks to the organization.
	Medium	A finding identified by Internal Audit that is considered to have a medium probability of adverse effects to the University either or to a college/school/business unit. As such, management may need to act to address the noted concern and reduce the risk to a more desirable level.
	Low	A finding identified by Internal Audit that is considered to have minimal probability of adverse effects to the University either or to a college/school/business unit. As such, management should consider whether to act to reduce the risk, or accept the risk as being within the University's risk appetite. Cost benefit analysis may be useful.

It is important to note that considerable professional judgment is required in determining the overall ratings presented on the previous pages of this report. Accordingly, others could evaluate the results differently and draw different conclusions. It is also important to note that this report provides management with information about the condition of risks and internal controls at one point in time. Future changes in environmental factors and actions by personnel may significantly impact these risks and controls in ways that this report did not and cannot anticipate.

Office of Internal Audit

Virginia State University

Configuration Management IT Security Audit Report

Internal Audit Report

January 28, 2025

This report is Freedom of Information Act Exempt (FOIAE) under § 2.2-3705.2 of the Code of Virginia due to it containing descriptions of security mechanisms

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EXECUTIVE SUMMARY

BACKGROUND

Configuration Management is a systematic approach to establishing and maintaining the consistency of a product's performance, functional and physical attributes over its life. It involves the identification, control and monitoring of changes to both the hardware and software components of a system. The key goals of configuration management include documentation, change control, version control, automation, audit and compliance. Configuration Management is essential in various industries, especially, in Information Technology (IT) and software development, to maintain reliability, enhance system security, and ensure smooth operational performance. Currently Virginia State University uses ServiceNow as it's platform for configuration management to help manage and maintain their IT infrastructure which focuses on controlling the various components that make up the IT environment.

Our audit of Virginia State University's configuration management process focused on two control families from the Commonwealth of Virginia Information Security Standard (SEC 530) and Virginia State University Information Technology policies. These two control families provide a framework of minimal requirements that Commonwealth agencies use to develop their information security programs, with a goal of allowing agencies to accomplish their missions in a safe and secure environment. These control families represent two pillars to successfully adhere to the "CIA triad", which are confidentiality, integrity, and availability.

The Control Families selected are:

Access Control - (AC)**:**
The Access control family is a fundamental component for data security that dictates who can access and use company information and resources. Through authentication and authorization, access controls ensure users are who they say they are and that they have appropriate access to company data.

Configuration Management**:**
The System and Information Integrity control family provides assurance that only approved changes to information system are done. And ensures that there is an automation change control system in place. Change request are retained. Impact analyses are completed to identify risk and that is a role back procedure in place.

EXECUTIVE SUMMARY

SCOPE AND OBJECTIVES

The Office of Internal Audit has completed its Configuration Management (IT) Security Audit. This report provides an analysis of the current IT controls surrounding Configuration Management and their effectiveness, and offers recommendations for improving security measures to mitigate potential vulnerabilities and threats. The audit scope included an evaluation of the University's security infrastructure, policies, and procedures as they relate to Configuration Management. The objectives were to test the adequacy and effectiveness of the University's security controls and configurations management process, and to ensure the controls in place are compliant with applicable state and federal laws, regulations, standards, and industry best practices. The steps performed were intended to provide reasonable assurance that the controls are working to protect the confidentiality, integrity, and availability of software, hardware and data during the configuration management process.

We reviewed for compliance with the University information technology (IT) security policies and procedures, and two of the 20 SEC 530 IT security control families: Access Control and Configuration Management.

CONCLUSION

Overall, the University's IT security concerning the configuration management is adequate and we noted no findings or exceptions. Accordingly, others could evaluate the results differently and draw different conclusions. It is also important to note that this report provides management with information about the condition of risks and internal controls at one point in time. Future changes in environmental factors and actions by personnel may significantly impact these risks and controls in ways that this report did not and cannot anticipate.